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ABSTRACT

The author examines the traditional emphasis of health educators in preventive approaches to smoking behavior and suggests (through a brief literature review) specific techniques that may be useful in aiding those who would stop smoking. (MJB)

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HEALTH EDUCATION: SMOKE STOP PROGRAMMING

by

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Health educators have always been concerned with smoking and tobacco education. The two major emphases of our educational programs have been preventive, that is education before starting will influence a no smoking behavior and smoke stopping education. These two approaches to tobacco and smoke stopping education must be constantly re-examined.

According to the President's Committee on Health Education (1971):

> This area includes such obvious violations of medical advice as cigarette smoking, faulty diet, lack of exercise, drug abuse, excessive use of intoxicants and indifference to safety measures.
>
> They represent a major weakness in the nation's past health education efforts. In the face of programs and campaigns, exhortations, appeals, warnings and even punitive legislation, results have not come close to reflecting the amount of money spent.
>
> In this area, ways must be found to persuade people to help themselves. Without question, it is the most difficult job of health education. (p. 18.)

St. Pierre and Lawrence stated (1975):

> ...health educators have attempted to alter their teaching methodologies or classroom strategies in the hope of hitting on a solid technique that emphasizes the adverse effects of smoking and produces consequent reduction in smoking behavior. Hopefully, such techniques might also prevent the non-smoking student from initiating smoking. This cognitive approach, teaching the facts and hoping for subsequent change in behavior has not proven over beneficial. (p. 7.)

This paper will suggest specific techniques which will enhance those educators who would like to aid those who desire to stop smoking.

The knowledge held by smokers, ex-smokers and non-smokers has been studied. Chen and Rakip (1975) reported that more ex-smokers and non-smokers believed smoking was related to health than did smokers. Foss (1973) stated many smokers did not believe that smoking will cause an early death. Evans (1967) concluded that persons desiring to stop smoking need simple medical facts reiterated constantly. Pervin and Yatko (1965) stated that smokers and non-smokers do not

disagree to any great extent on the evidence regarding smoking and its association to health, but rather they do disagree regarding the interpretation of that evidence. Other researchers have reported similar findings regarding smoking and health, including Schwartz and Dubitzky (1969), Boyle (1960), and Swinehart and Kirscht (1966).

Health educators who are considering the development of smoke stop clinics should consider the possibility of developing one or two sessions on the health effects of smoking. An emphasis of premature death may merit a concentrated effort of instruction.

Drinking patterns have been associated with smoking. Straits and Sechrest (1963) and Heath (1958) reported that smokers drink more alcohol and coffee than do non-smokers. Elliot and Tighe (1968) stated that social drinking was a most difficult situation for smoke stoppers. Matarazzo and Saslow (1960) noted that smokers drank more coffee than non-smokers.

The smoke stop programmers may want to suggest to the participants desiring to stop that they not drink coffee or alcohol during the first month or two of stopping. Drinks such as tea, chocolate, soda, etc. might be substituted for alcohol and/or coffee.

Behavior modification techniques can and should be used by health educators conducting smoke stop clinics. Having smoke stoppers reward themselves with special gifts or events such as an evening out on the town which notes short term successes can be beneficial. Utilizing money as a reward or punishment can also be used.

Harris and Rothbert (1972) implemented a positive reward component in their smoke stop program. They focused on two types of positive reward. One was material, while the other was social. They reported that their program produced success in that all five subjects reduced their incidence of cigarette smoking.

Health educators should not utilize rapid smoking techniques unless they know all the ramifications of such techniques. The health of the smoke stopper may be impaired when such a technique is incorporated. Only those appropriately trained should include this type of adversion therapy into their smoke stop clinics.

Self-monitoring should be seriously considered as part of the plan to aid the smoker to stop. McFall and Hammer (1971), McFall (1970) and Ober (1968) demonstrated in their studies that daily monitoring of cigarette smoking is an effective tool in reducing the incidence of cigarette smoking. Daily monitoring consisted of recording the incidence of smoking each day.

Self-control has merit as a component of a health educator's efforts to aid smokers to stop. Utilizing data collected by self-monitoring can become the basis for developing personalized plans to aid smokers to stop. Noting time, place, persons present, etc., when smoking is done can provide insight into the smoking pattern. Smoke stop programmers should not have the smoker avoid the situations where smoking is done but it would be of value to note the smoking situations so special conserted effort could be made to not smoke in such situations.

Conway (1977), Sipich, Russel and Tobias (1974) and Ober (1968) conducted studies which evaluated smoking reduction. They concluded that subjects were able to demonstrate reduction in smoke stopping when they utilized self-control.

The method of stopping appears to be associated with successful stopping. Boyle (1968) and Trahair (1967) questioned smoke stoppers. They both reported that the gradual method of smoking withdrawal was preferred less than the abrupt or "cold turkey" method. The Marston and McFall (1968) study indicated that the "cold turkey" method was the most successful method.

Relaxation has been studied as a component in smoke reduction programs. Marston and McFall (1971) and Wagner and Bragg (1970) reported successful reduction efforts with subjects who were taught relaxation. Many health educators may not know the educational techniques of teaching relaxation. The methods used are

reasonably simple. Most health educators could learn the teaching process of relaxation in a relatively short period of time if taught by a trained person.

Health educators can become more effective if they incorporate successful techniques of smoke stopping into their programs. We have failed to facilitate behavioral changes in our target populations because we have not utilized proven techniques. By incorporating successful techniques into our present day styles of health education we can become more effective. Consequently, the lives we touch through our educational efforts may become healtheir tomorrow.

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